DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 7/04/13

PRINTED: 05/31/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445239	A. BUILDING _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF TULLAHOMA	1715 N JACKSON ST TULLAHOMA, TN 37388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation of #30804, #30990, and #31690, was conducted on May 13 through May 15, 2013, at Life Care Center of Tullahoma. No deficiencies were cited related to complaint investigation #30804 and 31690. Deficiencies were cited related to complaint investigation #30990 under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview,	F 279	F - 279 A. What corrective action(s) will be accomplished for those residents found to have been affected: On 5/15/13, Minimum Data Set Coordinator updated care plan for resident #82 to include observations of increased risk of bleeding related to the potential drug interaction of Zoloft 100milligram and Ibuprofen 400milligrem. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? 1) On 6/3/13 the Minimum Data Set Coordinator/Minimum Data Set Assistants completed an audit of drug interactions on resident care plans. Corrections were made as needed. 2) Minimum Data Set Coordinator will educate resident upon changing resident care plan due to potential drug interactions. C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?	5/15/2013 6/3/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dana Julio
TITLE: Executive Director
(X6) DATE: 6/14/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	445238	A. BUILDING _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF TULLAHOMA	1716 N JACKSON ST TULLAHOMA, TN 37388

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F 279	Continued From page 1 the facility failed to develop a care plan for the increased risk of bleeding related to a potential drug interaction for one resident (#32) of forty-one residents reviewed. The findings included: Resident #32 was admitted to the facility on August 9, 2006, with diagnoses including Alzheimer's Disease, Bipolar Disorder, Hypothyroidism, and Depressive Disorder. Medical record review of a significant change Minimum Data Set (MDS) dated March 14, 2013, revealed the resident scored three out of fifteen on the Brief Interview for Mental Status indicating severely impaired cognitive skills. Continued review revealed the resident required limited assistance from one person for transfers, toileting, personal hygiene, and bathing. Review of a Physician's Order dated April 5, 2013, revealed Zoloft (a selective serotonin reuptake inhibitor) 100 milligrams to be given orally on a daily basis for depression. Review of the Physician's Recapitulation Orders dated May 2013, revealed the resident had an order for Ibuprofen (non-steroidal anti-inflammatory drug(NSAID) 400 milligrams to be given orally every four to six hours as needed for pain. Review of the Pharmacy's Potential Drug Interaction alert dated April 5, 2013, revealed, "...Drug Dispensed: Sertraline HCl (generic for Zoloft)...100 mg tablet. Interacts with: Ibuprofen 400 mg...Patient Management: Selective	F 279	1) Director of Nursing completed education with Minimum Data Set associates on 6/3/13 to ensure compliance with possible drug interactions on the care plan. 2) Upon receipt of drug interaction sheets from the pharmacy, the ward clerk will distribute the sheet to the Minimum Data Set Coordinator to ensure proper drug interaction revisions are noted on the care plan. 3) Director of Nursing will audit care plans requiring drug interactions weekly for 3 months for continued compliance. F-279 Continued D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place. Results of care plan audits will be reported and reviewed by the Performance Improvement Committee which includes the Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly Performance Improvement meeting and corrections made as needed.	6/3/2013 6/27/2013

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	445235	A. BUILDING _____ B. WING _____	05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF TULLAHOMA	1719 N JACKSON ST TULLAHOMA, TN 37388

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F 279	Continued From page 2 serotonin reuptake inhibitors...and NSAIDs should be used concurrently with caution. Patients should be warned about the increased risk of bleeding and be educated about signs and symptoms of bleeding." Review of the Care Plan dated March 14, 2013, revealed no documentation for observations of increased risk of bleeding related to the potential drug interaction. Interview with the MDS Coordinator in the MDS office on May 15, 2013, at 8:47 a.m., confirmed the MDS Coordinator had no knowledge of the Pharmacy alert, and stated "...I have never seen that..." referring to the information provided on the Potential Drug Interaction memo. Continued interview confirmed a Care Plan for the increased risk of bleeding related to the potential drug interaction had not been developed.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the	F 323	F - 323 A. What corrective action(s) will be accomplished for those residents found to have been affected: On 4/24/13, Assistant Director of Nursing educated resident #4 who is alert and oriented to help ensure that he is transferred with 2 people. The associate was also trained on 2 person transfer during toileting and to view the care guides prior to delivering care. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	4/24/2013

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	445238	A. BUILDING _____ B. WING _____	05/16/2013

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F 323	Continued From page 3 facility investigation, observation, and interview, the facility failed to ensure a safe transfer to prevent a fall for one resident (#4) of forty-one residents reviewed. The findings included: Resident #4 was admitted to the facility on May 13,1999, and readmitted to the facility on July 20, 2007, with diagnoses including Cerebral Palsy, Anemia, Hypertension, and Esophageal Reflux. Medical record review of the Quarterly Minimum Data Set dated February 3, 2013, revealed the resident was totally dependant with two person physical assistance for transfers and toileting. Medical record review of the current Care Plan revealed the resident required total assistance with activities of daily living. Medical record review of the Fall Risk Assessment dated February 14, 2013, revealed the resident was at risk for falls. Observation on May 14, 2013, at 5:00 p.m., revealed the resident seated in a motorized wheelchair in the resident's room. Review of a facility investigation dated April 24, 2013, revealed "...CNA (Certified Nursing Assistant) was transferring resident in BR (bathroom) from shower chair to w/c (wheelchair), CNA began leaning forward and fell (with) resident hitting...head against wall...(no injury) educated resident on need for gait belt during transfers/resident declines placement of gait belt. Resident is two person assist. Education (with)	F 323	1) On 6/4/13 and annually at skills fair the Certified Nursing Aide, Licensed Practical Nurse, and Registered Nurse staff are trained by the Director of Nursing and Assistant Director of Nursing on proper transfer procedures and where information on resident transfers is located. 2) On 6/4/13 Director of Nursing completed an audit on resident care plans requiring two person assistance with transfers in relation to assistance given weekly for three months. 3) Director of Nursing and Assistant Director of Nursing will audit witness statements weekly during incident meeting and incidents to ensure substantial compliance. F-323 Continued C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur? 1)On 6/4/13, Education completed by Director of Nursing with Registered Nurse, Licensed Practical Nurse and Certified Nursing Aide associates to ensure compliance in assisting with transfers and Activities of Daily Living in relation to the care plan. 2)Room-to-room observation audit will be completed twice weekly for first month, then weekly for two months by Director of Nursing, Assistant Director of Nursing, and unit managers to ensure compliance with assistance with transfers. Corrections and education will be made at time of audit if needed. D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.	6/4/2013 6/4/2013

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	443236	A. BUILDING _____ B. WING _____	05/15/2013

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F 323	Continued From page 4 employee on 2 person transfer..." Interview on May 15, 2013, at 7:30 a.m., with the Director of Nursing (DON) in the Human Resource Office, confirmed the resident was not transferred correctly using two person assistance.	F 323	Results of transfer audits will be reported and reviewed by the Performance Improvement Committee which includes the Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly Performance Improvement meeting and corrections made as needed.	6/27/2013
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, facility policy review, and interview, the facility failed to ensure the accurate receipt of a medication/controlled drug for one resident (#20) of forty-one residents reviewed.	F 425	F - 425 A. What corrective action(s) will be accomplished for those residents found to have been affected: On 5/14/13 Licensed Practical Nurse and Registered Nursing associates were in serviced on properly following the controlled drug policy by counting medications upon receipt from the pharmacy. B. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On 5/14/13 Director of Nursing and Assistant Director of Nursing completed an audit of controlled drugs to ensure compliance with documentation of receipt of controlled drugs. All controlled medications were accounted for. C. What measures will be put into place or what systematic changes will you make to ensure that the deficient practice will not recur?	5/14/2013 6/14/2013

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F 425	Continued From page 5 The findings included: Resident #20 was admitted to the facility on July 13, 2007, and readmitted on September 13, 2010, with diagnoses including Pneumonitis, Acute Kidney Failure, Dysphagia, Psychosis, and Urinary Tract Infection. Medical record review of the Physician's Recapitulation Orders dated December 2012, revealed the resident was to receive hydrocodone/acetaminophen (Lortab/pain medication) 5/325 mg (milligrams) by feeding tube twice daily and every six hours as needed. Medical record review of the December 2012, Medication Administration Record revealed the resident received the hydrocodone/acetaminophen 5/325 mg as ordered. Review of a facility investigation revealed on December 26, 2012, thirty tablets of Lortab, were discovered to be missing, after a nurse had requested the Pharmacy to refill the prescription for the Lortab. Continued review of the facility investigation revealed the Pharmacy reported the Lortab had been delivered to the facility on December 23, 2012. Continued review of the facility investigation revealed an undated signature of Licensed Practical Nurse (LPN) #1 as receiving the Lortab filled by Pharmacy on the evening of December 22, 2012. Continued review of facility documentation revealed LPN #1 did not log the Lortab onto the Narcotic Count Log (log of the number of proof of use sheets) when the medication was received. Continued	F 425	On 6/3/13 audit was completed by Director of Nursing and Assistant Director of Nursing on medication carts to ensure compliance with controlled drug policy. (Director of Nursing/Assistant Director Nursing) will continue audit 5 days a week for first month, then once weekly for two months by unit managers, Assistant Director of Nursing and Director of Nursing to ensure compliance with documentation of receipt of controlled drugs. F- 425 Continued D. How will the corrective action(s) be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place? Results of medication cart audits will be reported and reviewed by the Performance Improvement Committee which includes the Executive Director, Medical Director, Director of Nursing, Director of Marketing, Pharmacist, Director of Admissions, Director of Social Service, Rehab Services Manager, Director of Activities, Director of Environmental Services, Dietary Manager, Director Maintenance, Business Office Manager, Health Information Manager, and Staff Development Coordinator in Monthly Performance Improvement meeting and corrections made as needed.	6/3/2013 6/27/2013

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F 425	Continued From page 6 review of the facility investigation revealed the Lortab was not found. Review of facility policy, Controlled Drugs, revised February 2009, revealed "...A controlled drugs proof of use sheet is accurately maintained on all residents requiring controlled medications. Strict control of narcotics is always maintained...Appropriate storage, recording, and use of controlled drugs are maintained on all units. Narcotic proof of use sheet is accurately maintained on residents requiring such medication...The actual controlled drugs are counted, as is the number of 'proof of use sheets' and the number of 'bingo' cards (sleeves, bottles, etc.) The 'proof of use sheets' should have their own sheets and are subtracted or added..." Telephone interview on May 14, 2013, at 4:10 p.m., with LPN #1, revealed LPN #1 had received the Lortab from the pharmacy on December 23, 2013. Continued interview confirmed the card of Lortab tablets was not documented in the notebook tracking the number of cards of controlled medications (Narcotic Count Log). Continued interview revealed the medication was placed in the medication supply and the Controlled Substance Drug Use Sheet was placed into the notebook of controlled drugs at the time the medication was delivered to the facility. Continued interview confirmed the facility's policy for Controlled Drugs was not followed. Continued interview revealed LPN #1 denied taking the Lortab. Interview on May 14, 2013, at 4:16 p.m., with the Director of Nursing (DON), in the DON's office, revealed on December 28, 2012, a Nurse had	F 425		

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	445228	A. BUILDING _____ B. WING _____	05/15/2013

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F 425	Continued From page 7 called the Pharmacy to refill resident #20's Lortab, and the Pharmacy had been unable to refill the prescription due to the medication being filled on December 22, 2013, and delivered to the facility on December 23, 2012. Continued interview revealed it was the facility's policy to add the card of controlled medications when received into the notebook documenting the number of cards of controlled drugs located in the medication cart (Narcotic Count Log). Continued interview revealed the count sheet and the card containing the thirty tablets of Lortab were never found. Continued interview confirmed LPN #1 had not followed the facility's policy for adding the Lortab to the card count in the notebook documenting the number of cards of controlled substances located in the medication cart. C/O #30980	F 425		